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DEPARTMENT OF HEALTH AND HUMAN SERVICES OTC 9/7/12
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #1	445427	A. BUILDING _____ B. WING _____	C 07/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE CENTER	444 ONE ELEVEN PLACE COOKEVILLE, TN 38501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During complaint investigation of #29220, #29575, and #29842, conducted on July 23 - 24, 2012, at Bethesda Health Care Center, no deficiencies were cited in relation to complaints #29220 and 29575 under 42 CFR PART 482.13, Requirements for Long Term Care.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225	F 225 483.13(c)(1)(ii)-(iii), (c)(2) – (4) Investigate/Report Allegations/Individuals Requirement: The facility will not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law. The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility will have evidence that all alleged violations are thoroughly investigated, and will prevent further potential abuse while the investigation is in progress. The result of all investigations will be reported to the administrator or his designated representative and to other officials in accordance with State law within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	8/9/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record reivew, facility investigation review, and interview, the faciity failed to conduct an investigation and report the results of the investigation to the State Agency related to a resident's allegation of sexual abuse for one (#2) of ten residents reviewed. The findings included: Medical record review revealed resident #2 was admitted to the facility on March 23, 2012, with diagnoses to include Diabetes Mellitus, Atrial Fibrillation, Gastroesophageal Reflux Disease, Hypertension, Coronary Artery Disease, Left Bundle Branch Block, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Avascular Necrosis, and Macular Degeneration. Review of the Minimum Data Set dated June 13, 2012, revealed the resident scored 12 out of 15 (indicating moderately impaired cognitively) on the Brief Interview of Mental Status; required extensive assistance with bathing, dressing, grooming, and transfers; ate after setup; was continent of bowel and frequently incontinent of bladder; and used a wheelchair for mobility.	F 225	F 225 483.13(c)(1)(ii)-(iii), (c)(2) – (4) Investigate/Report Allegations/Individuals Corrective Action: 1. On 7/25/12 the Administrator reviewed facility patients to ensure that there were no patients who required an investigation into any alleged allegations of abuse. Facility currently conducts background checks on all employees prior to hire. 2. On 8/9/12 the Administrator conducted in-service training to staff members concerning the appropriate response to alleged violations involving mistreatment, neglect, or abuse; including injuries of unknown origins. 3. The facility Administrator, DON, ADON, Staffing Coordinator, and Treatment Nurse will monitor for compliance through weekly observations X 90 days. Findings will be reviewed in Quality Assurance Committee. Additional in-services will be held with staff concerning appropriate responses to allegations of abuse.	8/9/12

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F 225	Continued From page 2 Review of nursing notes dated May 16, 2012, at 5:45 p.m., revealed the resident was moved to another room "...which has caused increased confusion. Rolling in other peoples' rooms, taking remote to wrong patient's room. Daughter here at bedside trying to redirect patient...". Continued review of nursing notes revealed no bruising apparent. Review of nursing notes dated May 19, 2012, at 9:30 a.m., revealed resident was alert but drowsy. Continued review revealed resident would wake up to answer questions but was slow to respond. Further review of nursing notes at 1:00 p.m., revealed "...patient continues to be very drowsy. Will answer questions then falls back to sleep again. Daughter here visiting and pt. (patient) unable to state name...". Continued review of nursing notes revealed the physician was notified of the changes and ordered the resident to be transferred to the hospital. Review of nursing notes from the hospital dated May 19, 2012, at 7:46 p.m., revealed "...bruising noted to both inner thighs with left worse than right moderate size hematoma noted to left inner thigh...". Review of the History and Physical examination dated Mat 29, 2012, revealed the integumentary (skin) system was "...intact with bruising that appears to be approximately three days old on the medial thighs bilaterally, left greater than right, and extensive perineal candidiasis (infection) and maceration appearance...". Review of a written statement by the admitting nurse, dated May 19, 2012, at 7:58 p.m., revealed	F 225		

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F 225	Continued From page 3 "...bruises were noted on both medial mid-lower thigh - left bruise was worse than right. Left was approximately 4" x 2", purple/blue colored and irregular shaped and firm to touch. Right had 2" x 2" area approximately - irregular shaped with some smaller circular spots to lower thigh - blue/purple colored...". Continued review of the written statement revealed "...daughter asked patient about bruises; pt reports having a dream about being checked down there. Pt. reported a teenage boy with glasses and a girl came into room and told resident they were going to tie her up. Pt. reports them tying down right leg. Pt. reports kicking at them. Pt. reports falling asleep with leg tied and waking up with it off the bed. There was a light on. In the bed next to resident was a girl and a teenage boy. Pt. told them to untie...and get out of...room...". Review of a consultation by a Gynecologist dated May 22, 2012, revealed "...while in hospital the patient had made comments which the caretakers had questioned if pt had had inappropriate touching to genitalia. They had noticed some bruising in genitalia. When I arrived and began asking the patient questions, the pt. stated...did not want to talk about this further and this was possible a dream...". Continued review of the consultant's note revealed "...Alleged sexual assault, however, the patient now declining exam, states this was a mistake. I have discussed with the patient and family quite openly that a file case could be opened and an alleged sexual assault/rape kit be performed. Pt adamantly declines again. I have told...I would be happy to examine...just simply myself and perform a gynecology exam, again...declines...".	F 225		

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F 225	Continued From page 4 Review of Case Management notes dated May 20, 2012, at 10:00 a.m., revealed "...patient reports what...thinks are dreams about things that are happening at (named nursing home) but is not sure they are dreams. Review of a Social Worker note dated May 20, 2012, at 11:41 a.m., revealed "...attempted to meet with patient and daughter regarding bruising and dreams pt. reported to CM (Case Manager). Pt's son was in room and obviously had no knowledge of concerns...". Continued review of Social Worker notes dated May 20, 2012, at 12:24 p.m., revealed "...Pt. care conference with physician who reported bruising was low on leg and was consistent with the pt's report of (named Nursing Home) using a lift approx (approximately) 1 week ago...". Further review of a Social Worker note dated May 22, 2012, at 12:22 p.m., revealed "...Social Worker was notified earlier this a.m. by nurse of pt. continuing to make remarks to nursing about inappropriate situation. Physician has consulted with Gynecologist. Director of Case Management requested Social Worker and Director meet with daughter and pt. before Gynecologist visits pt. When visiting with pt...became visibly distressed when asked to tell what...thinks has happened. Pt. did state...did not want to tell it again...". Continued review of the Social Work note dated May 22, 2012, at 3:09 p.m., revealed "...Social Worker, Gynecologist, and nurse met with patient and daughter. Pt. refused to discuss incident saying "I told you I was through discussing it. I do not want to get anyone in trouble...". Further review of Social Worker notes dated May	F 225		

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F 225	Continued From page 5 24, 2012, at 9:03 a.m., revealed Adult Protective Services had been notified of the incident, and the patient was discharged back to the facility. Review of facility Social Services note dated May 23, 2012, revealed "...Adm Coord (Admissions Coordinator) and DON (Director of Nursing) found that a consultation had been done at the hospital on May 22, 2012, by (named physician) due to patient making comments that caretakers had questioned if...had inappropriate touching to the genitalia. They had noticed some bruising in the genitalia area also. Went to Administrator with these concerns and Administrator called resident's son who stated he strongly believed it was just a dream and nothing really happened. He stated he and resident want it dropped. He also stated if he felt any of this was true he would not be allowing resident to come back to facility. Patient has to have a lift used for all transfers. The bruises were noted to be where lift is used...". Continued review of a Social Services note dated May 24, 2012, revealed "...APS (Adult Protective Services) worker came to investigate the consultation done at hospital. Adm Coord explained to APS worker patient had to be transferred with a lift and the bruising was located on...inner thighs and under...arm where the lift sling would be...". Further review of a Social Services note dated June 5, 2012, revealed "...APS worker here to see patient. Adm Coord showed lift and sling to APS worker. The Adm Coord had CNA (Certified Nursing Assistant) demonstrate how lift was used. CNA put patient in the lift and showed	F 225		

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F 225	Continued From page 6 where the sling wraps around legs. Patient stated the bruises did not come from the lift we were using but it was a lift that made...stand up. CNA stated the stand up lift had been used once but they were not using it anymore because it was uncomfortable for the patient. Patient began to tell APS worker...had been out of...mind lately and had been having dreams. Stated...was better now and nothing had happened...". Interview with the Admissions Coordinator on July 23, 2012, at 2:55 p.m., in the conference room, revealed the resident had a urinary tract infection and went to the hospital. Continued interview revealed, while at the hospital, "...the resident said...had a dream...had been sexually assaulted...". Further interview revealed the facility was unaware of this until they were notified the resident was returning to the facility and the History and Physical as well as the consultation were sent to them. Continued interview revealed the administrator called the son who stated the resident had crazy dreams and if he felt the resident was abused he would not bring...back to the facility. Further interview revealed the Admissions Coordinator showed the lift to the APS worker but the resident stated that was not the one which caused the bruises but rather the stand-up lift. Continued interview revealed the "...straps on the stand-up lift matched and were identical to areas of bruising on the resident's inner thighs...". Further interview with the Admissions Coordinator revealed there had not been an internal investigation conducted regarding the bruises and allegations and the results of an investigation reported to the Sate Survey and Certification Agency .	F 225		

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F 225	Continued From page 7 Interview with the Administrator and Director of Nursing (DON) on July 24, 2012, at 1:30 p.m., in the conference room, revealed the facility felt they knew the cause of the bruising, and it was the stand-up lift. Continued interview revealed they felt the facility was not the primary investigator since the allegations were made to hospital staff and not facility staff. C/O 29842	F 225		